Attachment K

Request for Premium Waiver

Dear KidsCare Family:

Per your request, we are sending you this form to use to ask for a waiver of your child(ren)'s premium(s). To ask for a waiver, you must:

- Fill in this form;
- **Attach proof of the expenses** (copy of your health insurance premium bill, copy of the bill or receipt for the repair to your home or vehicle, copy of your doctor or hospital bill, etc.); and
- Send the completed form and proof in the enclosed postage paid envelope.

We must get this form by _____. If we do not get the completed form and proof by this date, we will deny your request and you will have to pay your premium to keep your child(ren)'s KidsCare benefits.

1. Did you have medically necessary expenses that are not covered by AHCCCS or other insurance last month or this month? ❑ No ❑ Yes If yes and you can send proof of the expense(s), answer the questions below.

Name of person who received the service	Type of service	Name of person who needs to pay the bill	Month(s) paid or will be paid	Amount paid or will be paid

2. Do you have health insurance premiums for any member of your household?
❑ No ❑ Yes If yes and you can send proof of the expense(s), answer the questions below.

Name of person who has insurance	Name of person who needs to pay the bill	Month(s) paid or will be paid	Amount paid or will be paid

3. Did you have unexpected repairs to your home or the vehicle you use to get to work last month or this month? (This does not include painting or remodeling your home or routine vehicle maintenance such as tune-ups, oil changes, etc.) ❑ No ❑ Yes If yes and you can send proof of the expense(s), answer the questions below.

Type of Repair	Month(s) paid or will be paid	Amount paid or will be paid

4. Did a member of your household die last month or this month?
❑ No ❑ Yes If yes, who? _____ Date household member died? _____

5. Has your household income changed since your last application?
❑ No ❑ Yes If yes, answer the questions below.

Name of person receiving income	Name and address of employer, agency, or person who provides income	Telephone number of employer, agency or person	How often paid? (weekly, biweekly, monthly, quarterly, yearly, etc.)	Gross amount (before deductions) Received each time	Hours worked per week	Hourly rate	Overtime hours worked per week	Overtime hourly rate
				$ per period		$ per hr.		$ per hr.
				$ per period		$ per hr.		$ per hr.

I swear under penalty of perjury that the statements made on this request and any other statements that I made (or will make) relating to my request for a hardship exemption are true and correct to the best of my knowledge. Photocopies I have provided are the same as the original document.

Signature:	**Date:**